TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John P. Obermiller, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-14-2522-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This appointment consisted of *two* separate evaluations: Extent of Injury and Diagnosis Related Estimate (DRE) with one body area. Per the Texas Department of Insurance Division of Workers' Compensation Medical Fee Guidelines (§134.202), these are separately billable services. The fee for an Extent of Injury $500.00 each; DRE with one body area is an additional $500.00. Total billing for these evaluations is $1000.00."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, as RME doctor, was asked to determine MMI/IR and Extent of Injury. The requestor did this and billed 99456WP and 99456RE. Texas Mutual paid the requestor $500.00 for the MMI/IR exams.

The requestor billed the Extent exam using a modifier for Return to Work exam, i.e. RE. No payment is due for this billing."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2013	Post-Designated Doctor Required Medical Examination	$250.00	$250.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-W1 – Workers Compensation state fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-18 – Duplicate claim/service.
   - 224 – Duplicate charge.
   - CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 723 – Supplemental reimbursement allowed after a reconsideration of services.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation… (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used." The submitted documentation indicates that the requestor performed an evaluation to determine the impairment rating of the spine using the DRE method found in the AMA Guides 4th edition. Therefore, the correct MAR for this examination is $150.00.

   Per 28 Texas Administrative Code §134.204 (k),

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   The submitted documentation indicates that the Designated Doctor performed an examination to determine the extent of the compensable injury. Therefore, the correct MAR for this examination is $500.00.

2. The total MAR for the disputed services is $1000.00. The insurance carrier paid $750.00. An additional reimbursement of $250.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $250.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.